Applying for Public Assistance Health Care Programs in Wisconsin

Overview for Navigators, Certified Application Counselors, Agents, and Brokers

GOALS

The goal of this training is to provide Navigators, Certified Application Counselors (CACs), Agents, and Brokers:

- An overview of public assistance health care program eligibility requirements with a focus on BadgerCare Plus and Elderly, Blind, and Disabled (EBD) Medicaid.

  and

- Information about the methods of applying for public health care programs in Wisconsin and what to expect throughout the application process.

PURPOSE

After taking this course, a Navigator, CAC, Agents, and Brokers should have a basic understanding of:

- General eligibility requirements
- Methods through which an applicant may apply for public health care assistance in Wisconsin
- What the applicant can expect throughout the process

This training, along with the separate training about the Health Insurance Marketplace, provides Navigators and CACs the knowledge to help a client enter the health care application process through the most appropriate route.

IM AGENCY ROLE

- This is a high level overview of BadgerCare Plus and Medicaid eligibility requirements relevant to applicants whose eligibility is being determined for January 1, 2014. This is **NOT** a training on determining eligibility. Only Income Maintenance (IM) agencies can determine eligibility.

- This training does not cover BadgerCare Plus benefits available *before* January 1, 2014.

****Note**:** At any time policy and processes are subject to change. For updated public assistance health care benefits information please see http://www.dhs.wisconsin.gov/forwardhealth/

IM AGENCIES

- IM agencies are local county and tribal agencies that determine eligibility and issue benefits for the Wisconsin BadgerCare Plus and Medicaid programs.
- In Wisconsin, local IM agencies are organized in to 10 IM Consortia.
  - Menominee Tribal Agency is not within an IM Consortia
  - IM functions in Milwaukee are administered by the State of Wisconsin Department of Health Services through Milwaukee Enrollment Services (MilES).
- To see which IM agency services your client's geographic area visit:
  - http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

TRAINING OVERVIEW

An overview on the following will be provided:

- Wisconsin's Health Care Programs
- Eligibility Requirements
  - Non-Financial
  - Financial
- Guide to Applying
- Covered Services
- Verification Requirements
- What to Expect After an Application is Submitted
- Member Rights & Responsibilities

PROGRAMS AVAILABLE

Within this training, we will introduce you to various public assistance health care programs in Wisconsin. The programs we will discuss include:

- BadgerCare Plus,
- Medicaid for the Elderly, Blind, and Disabled (EBD), and
- Long Term Care Medicaid.

APPLICATION

It is important to understand that when a customer applies for a public assistance health care program through one of the methods described in this training, the following apply to each application:

- His/her eligibility will be determined by the Income Maintenance agency for the appropriate program based on his/her circumstance.
- An individual does not need to specify if they are applying for BadgerCare Plus or EBD Medicaid.
- One application will be used to determine his/her eligibility for the appropriate health care program.

Wisconsin's Health Care Programs

BADGERCARE PLUS

- BadgerCare Plus (BC+), including:
  - Coverage for eligible children, parents/caretakers, childless adults, and pregnant women
  - Family Planning Only Services (FPOS)
  - BC+ Prenatal Program

EBD MEDICAID

- Medicaid for the elderly, blind, and disabled (EBD), including the following programs:
  - Supplemental Security Income (SSI) Medicaid
  - SSI-Related Medicaid
  - Medicare Premium Assistance (QMB, SLMB, SLMB+)
  - Medicaid Purchase Plan (MAPP)

LONG TERM CARE MEDICAID

- Long Term Care Medicaid, including:
  - Institutional Medicaid
  - Family Care

Health Care Eligibility Requirements

BASIC ELIGIBILITY REQUIREMENTS

- Wisconsin resident
  - Physically present with an intent to reside in Wisconsin
- US Citizen or qualifying immigrant
- Provide social security number (with some exceptions)
- Supply required information and verification (proof) on time
- Monthly income must be below program limits
- When applicable
  - Payment of premium or deductible
  - Assets below program limits for Medicaid for elderly and/or disabled individuals

BadgerCare Plus (BC+)

BADGERCARE PLUS

BadgerCare Plus (BC+) is a State of Wisconsin health care program that provides health coverage for certain children, parents/caretakers, childless adults, and pregnant women residing in Wisconsin.

BC+ POPULATIONS

Populations Served **(effective January 1, 2014):**

BC+ Adults	BC+ Children	BC+ Pregnant Women
• Ages 19-64 • Non-disabled/Non-Pregnant • Household income at or below 100% of the FPL • Includes parents, caretakers, and adults without dependent children	• Children under 19 years old • Household income at or below 300% of the FPL • Children with household income over 200% will be required to pay a premium	• Household income at or below 300% of the FPL

BADGERCARE PLUS GROUPS

- BC+ financial eligibility determinations are based on an estimated projection of the household's current monthly income.
- Within a BC+ group ALL members' income is counted, with one exception:
  - Effective January 1, 2014, if a group member is a child or tax dependent of another group member, his or her income is only counted if he/she is 'expected to be required' to file a tax return for the current year.
- Only IM agencies can determine BC+ group size, income, and household member eligibility.

Financial Eligibility & Modified Adjusted Gross Income (MAGI)

BC+ FINANCIAL ELIGIBILITY

- Beginning January 1, 2014, the Marketplace will use tax rules to calculate income.
- Wisconsin will also use these same rules to determine eligibility for BC+ coverage that **begins on or after January 1, 2014**.
- These rules are known as the Modified Adjusted Gross Income, or MAGI, methodology.

BC+ INCOME

For BC+ coverage that begins on or after January 1, 2014, countable income for BC+ will consist of taxable income. Some types of countable income under MAGI methodology for BC+ will include:

- Taxable Gross Earned Income
- Taxable Self-Employment Income
- Unemployment Compensation
- Alimony/Spousal Maintenance
- Social Security Income

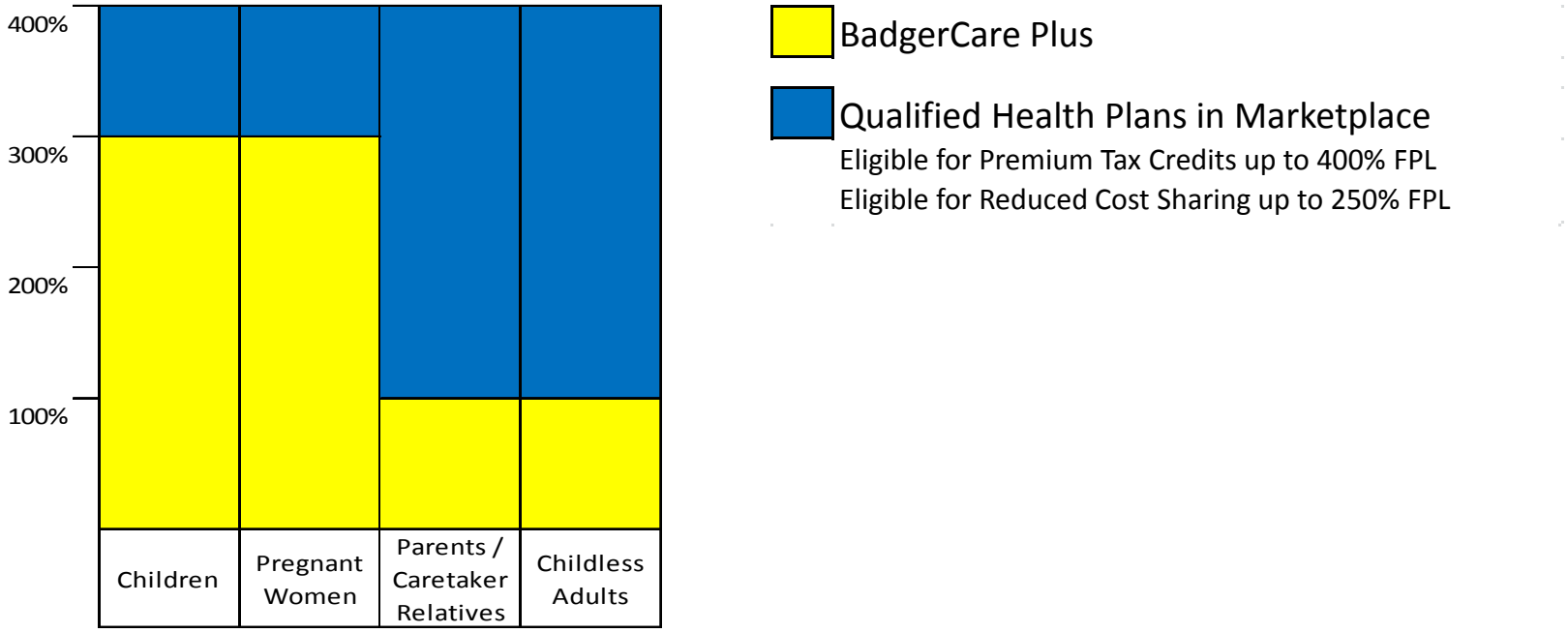
BC+ INCOME

Some common income types that will **NOT** be counted for BC+ eligibility include:

- Child Support
- Supplemental Security Income (SSI)
- Worker's Compensation
- Veteran's Benefits

BC+ FINANCIAL ELIGIBILITY SUMMARY CHART

The following chart displays the income limits for potential BC+ members as well as for the Qualified Health Plans in the Marketplace for coverage beginning on or after January 1, 2014:



FPL CHART

The Federal Poverty Level Chart can be found at the website below:

http://www.dhs.wisconsin.gov/badgercareplus/fpl.htm

Note: there is no maximum amount of available assets (such as savings accounts and real property) that a BC+ applicant or member is allowed to have.

BC+ MAGI GROUP

- Determining a BC+ MAGI group size is complex. A single BC+ application may result in one open BC+ case, with several different group sizes.
- BC+ MAGI groups will be person specific; therefore, IM agencies will have to determine group size one person at a time.
- Each group will be formed around an individual who is requesting assistance. The individual's group will be based on the:
    - Age,
    - Marital status,
    - Tax filing status, and
    - Tax relationships and/or family relationships.

BC+ MAGI GROUP

- Using MAGI methodology, each group will be formed using either tax rules or relationship rules.
- If the applicant is a tax filer and NOT also a tax dependent, the group will be formed using tax rules.
- If no one in the home will be filing taxes, the group will be formed using relationship rules.

BC+ MAGI GROUP – TAX FILING HOUSEHOLDS

- For tax filing households, most rules are based on, “what the household expects to do” with regard to filing taxes for the given year, with groups generally formed based on tax filing relationships.
- IM agencies determining MAGI groups will look at:
  - Who is filing taxes,
  - If the tax filer is being claimed as a tax dependent, and
  - If applicable, who the tax filer’s tax dependents are.

****Note**:** In order for a parent to request BC+ assistance for their child(ren), they must have physical placement of their child(ren) at least 40% of time each month.

BC+ MAGI GROUP – TAX FILING HOUSEHOLDS

If the applicant is a tax filer and NOT also a tax dependent, the applicant's group will be made up of:

- The applicant,
- The applicant’s spouse (included if they are living in the home and filing separately or if they’re filing jointly and living separately), and
- Any tax dependents the applicant expects to claim, including deceased individuals and individuals living outside of the home.

BC+ MAGI GROUP – NON-TAX FILING HOUSEHOLDS

If no one in the home will file taxes (and in certain other exception situations), IM agencies will use Relationship Rules to determine an individual's group size:

- If the applicant is age 19 or older, and relationship rules are being used, the group size will include:
  - Applicant,
  - Applicant's spouse, and
  - Applicant's children under age 19.
- If the applicant is under age 19 and relationship rules are being used, the group size will include:
  - Applicant,
  - Applicant's spouse,
  - Applicant's children under age 19,
  - Applicant's parents, and
  - Applicant's siblings (including half- and step-siblings) under age 19.

BC+ MAGI GROUP – DIVORCED

When parents are divorced:

- Only one parent can claim the child as their tax dependent in a given year.

If both parents are filing taxes:

- Only one parent will have the child included in his/her MAGI group.

If only one parent is filing taxes or if no parent is filing taxes:

- It is possible that both parents will have the child in their MAGI group.

****Note****: If neither parent is filing taxes, and the child lives with both parents at least 40% of the time, the child may be put into both parents' MAGI groups due to relationship rules.

EXCEPTIONS AND OTHER SITUATIONS

There are many factors IM agencies consider when building household composition, as well as many special rules and exceptions under MAGI rules.

Individuals with the following complex household compositions should discuss their individual situation with their IM agency :

- situations of non-marital co-parents,
- married parents who file taxes separately, or
- situations where a child is being claimed as a tax dependent by a non-custodial parent.

BC+ GROUP SIZE – EXAMPLES

The following are a few examples to think about (for coverage beginning on or after January 1, 2014):

Example 1: A single mother with two children is applying for health insurance coverage. She works part time. Her income is at 70% of the FPL (below the 100% income limit for adults, and below the 300% income limit for children). She will likely be eligible for BC+/Medicaid, so it would be beneficial to apply directly for BC+/Medicaid.

Example 2: A single mother with two children is applying for health insurance coverage. She works full time. Her income is at 375% of the FPL (above the income limit for adults & children). She is not likely to be eligible for BC+/Medicaid, so would it be most beneficial to apply directly for health care through the Marketplace.

****NOTE** - ONLY IM AGENCIES CAN DETERMINE BC+ ELIGIBILITY**

BC+ OTHER POPULATIONS

Family Planning Only Services (FPOS) and Former Foster Care Youth

Family Planning Only Services	Former Foster Care Youth
• Provides limited benefits for men and women. • Income at or below 300% of the FPL. • 15 years of age or older • Not enrolled in BC+ without a premium or receiving other full benefit Medicaid .	• Full benefit Medicaid. • Any youth who were in foster care when they turned 18. • Are eligible for BC+ up to age 26 (beginning January 1, 2014). • No income limits for this population.

Medicaid for the Elderly, Blind, and Disabled (EBD)

MEDICAID INTRODUCTION

- Medicaid is a state/federal program that provides health coverage for Wisconsin residents that are elderly, blind, or disabled (EBD).
- Medicaid is commonly referred to as "Medical Assistance," "MA," and/or "Title 19."

****NOTE****: EBD Medicaid eligibility criteria is unaffected by the changes to BadgerCare Plus beginning January 1, 2014.

MEDICAID SUBPROGRAMS

Subprograms of Medicaid, include but are not limited to:

- Supplemental Security Income (SSI) Medicaid
  - IM agencies do not determine Medicaid eligibility for SSI recipients; eligibility is determined by the Social Security Administration.
- SSI-Related Medicaid
  - IM agencies determine eligibility for applicants.
- Medicaid Purchase Plan (MAPP)
- Medicare Premium Assistance (Medicare Savings Programs)
- Long Term Care Programs, including but not limited to:
  - Institutional Medicaid
  - Family Care

GENERAL EBD MEDICAID ELIGIBILITY CRITERIA

- To be non-financially eligible for EBD Medicaid, the applicant must be:
  - Elderly (65 years or older), or
  - Determined blind, and/or
  - Determined disabled.
- Meet the other general eligibility requirements, including:
  - Wisconsin resident
    - Physically present with an intent to reside in Wisconsin
  - US Citizen or qualifying immigrant
  - Provide social security number (with some exceptions)
  - Supply required information and verification (proof) on time
  - Pay any premiums or cost-sharing, if required.

EBD MEDICAID GROUPS

- Generally, an EBD Medicaid group includes the individual who is non-financially eligible for Medicaid and anyone who lives with them, and who is legally responsible for them.
  - This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses (this would be a group size of two).
  - There are some exceptions to this general rule, for example a blind or disabled minor living with their parents would be a group size of one.

EBD MEDICAID PROGRAM ELIGIBILITY

- An individual may fit into one (or more) EBD subprogram(s).
  - A person is eligible if she or he meets all program non-financial and financial requirements.
- Individuals who are not elderly, or determined blind or disabled (EBD) may be eligible for BC+.

SSI MEDICAID ELIGIBILITY

- SSI recipients are generally eligible for SSI Medicaid.
- Federal eligibility for SSI cash payment = eligibility for Wisconsin Medicaid and state supplemental payments.

SSI-RELATED EBD MEDICAID FINANCIAL CRITERIA

Individuals who are elderly, blind, and/or disabled may be eligible for SSI-Related Medicaid. **Note**: SSI payments are not required for this type of Medicaid.

- Unlike BC+, EBD Medicaid and subprograms generally include both income **and** asset tests.
- Income limit: up to $781.78 (single) and up to $1180.05 (married couple) per month. (**Note** that this income limit is not based on FPL).
- There are some income disregards that are taken into consideration. Details can be found in the Medicaid Eligibility Handbook (available at http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm in section 15).
- Countable assets below $2000 for a single individual, and $3000 for a married couple.
  - Common assets include cash, checking/savings accounts, some vehicles, non-home real property, some life insurance policies, burial assets, among others.

SSI-RELATED MEDICAID DEDUCTIBLES

- If household income exceeds the limit, a spend down is calculated. (Spend down amounts are calculated for a six month period by comparing the total countable monthly income to $591.67 and multiplying the difference by six.)
  - Unpaid and recently paid medical bills are used to “meet” the spend down. Proof is required.
  - Once the spend down is met, Medicaid pays for covered services until the end of the six month period.

MEDICAID PURCHASE PLAN ("MAPP")

- MAPP is for disabled individuals who are working or enrolled in a Health and Employment Counseling program.
- The program allows disabled people (who are working or want to work) to become or remain Medicaid eligible, even if employed, since MAPP has a higher income and asset limits.
  - Income limit is 250% FPL
    - There is a premium requirement if income exceeds 150% FPL
  - Asset limit is $15,000

MEDICARE PREMIUM ASSISTANCE (MSP)

- Medicare Premium Assistance is also commonly referred to as “Medicare Savings Program” or “MSP.”
- Medicare generally charges beneficiaries coinsurance, deductibles, and monthly premiums, referred to as "Medicare cost-sharing.”
- For certain Medicare beneficiaries, participating in a Medicare Premium Assistance program helps pay some of or the entire Medicare cost-sharing.

MEDICARE PREMIUM ASSISTANCE PROGRAMS

The following Medicare beneficiaries may be eligible for Medicare Premium Assistance:

- Qualified Medicare Beneficiary (QMB)
  - Medicaid pays Medicare Part A & B premiums and Medicare deductibles and coinsurance.
- Specified Low-Income Medicare Beneficiary (SLMB)
  - Medicaid pays Medicare Part B premiums.
- Specified Low-Income Medicare Beneficiary Plus (SLMB+)
  - Medicaid pays Medicare Part B premiums.
- Qualified Disabled and Working Adults (QDWI)
  - Medicaid pays Medicare Part A premiums.

MEDICARE PREMIUM ASSISTANCE INCOME & ASSET LIMITS

- QMB - 100% FPL
- SLMB - 120% FPL
- SLMB+ - 135% FPL
- QDWI - 200% FPL

Asset limits for QMB, SLMB, and SLMB+ are $6,940 (single) and $10,410 (married couple).

The asset limit for QDWI is $4,000 (single) and $6,000 (married couple).

Long Term Care (LTC) Medicaid

LONG TERM CARE (LTC) MEDICAID

Long-Term Care (LTC) Medicaid includes services and support that a person needs due to age, disability, or chronic illness which limits his/her ability to perform everyday tasks.

COMMON LTC PROGRAMS

- Institutional LTC Medicaid – for EBD individuals residing in a nursing home, hospital, or other medical institution.
- Family Care – enables EBD persons to live in community settings rather than medical institutions.
- Include, Respect, I Self-Direct (IRIS) – offered to individuals as an alternative to Family Care.

****Note****: Aging and Disability Resource Centers (ADRCs) serve as the access point for Family Care, IRIS, and other publicly funded long-term care programs and applications. However, persons interested in Institutional LTC Medicaid can apply on their own.

INSTITUTIONAL LTC MEDICAID

- An “institutionalized person” means someone who:
  - Has resided in medical institution for 30 or more consecutive days, or
  - Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.
- An “institution” means medical institution, including but not limited to hospitals, skilled nursing facilities, intermediate care facilities, and institutions for mental disease.

FAMILY CARE

- Family Care is a comprehensive and flexible LTC Medicaid program supporting adults with physical and developmental disabilities and frail elders.
- Family Care's goals:
  - Choice – give people better choices about the services and supports available to meet their needs.
  - Access – improve access to services.
  - Quality – improve quality through a focus on health and social outcomes.
  - Cost-effectiveness – create a cost-effective LTC system for the future.

FAMILY CARE FUNDING

- Managed Care Organizations (MCOs) get a payment for every member enrolled.
- MCOs provide members with:
  - The right service
  - In the right amount
  - At the right time
  - In the right setting
- There is no set budget for each member.

IRIS

- Serves same target groups as Family Care – adults with physical or developmental/intellectual disabilities and frail elders.
- People receive an individual budget to pay for needed services.
- Participants get support, as needed, from the IRIS Consultant Agency and Financial Services Agency.
- Encourages individualized and creative support opportunities.

IRIS

- IRIS is offered to individuals as an alternative to Family Care.
- Grounded in the principles of self-determination:
  - Freedom to decide how you want to live your life.
  - Authority over a determined budget amount.
  - Support to meaningfully organize and direct services.
  - Responsibility to use your public dollars wisely.
  - Confirmation of the individual's role in affecting change.

ADRCs

- ADRCs serve as a single access point for publicly funded LTC Medicaid programs (i.e. Family Care, IRIS), and provide eligibility determination and enrollment counseling.
- ADRCs are statewide and are a public service that anyone can use. Services are available regardless of income or eligibility for programs. Families, friends, caregivers, physicians, hospitals, and others use ADRCs.
- ADRCs provide:
  - Community Outreach
  - Information & Assistance
  - Long Term Care Options Counseling
  - Benefits Counseling
  - Pre-Admission Consultation/Nursing Home Relocations
  - Community Needs Identification
  - Access to Publicly Funded Long-Term Care Programs
  - Short Term Service Coordination
  - Transitional Services for Students and Youth
  - Prevention and Early Intervention Services
  - Client Advocacy

ADRCs

- Are welcoming and accessible places where older people and people with disabilities can obtain information, advice, and help in locating services or applying for benefits.
- Serve as a central source of reliable and objective information about a broad range programs and services.
- Help people learn how to conserve their personal resources, maintain self-sufficiency and delay or prevent the need for potentially expensive long-term care.
- To find an ADRC in your area, click here: **http://www.dhs.wisconsin.gov/LTCare/adrc/customer/map/index.htm.**

Guide to Applying

GUIDE TO APPLYING

The Guide to Applying is a helpful resource that can be given to applicants or members. Click the link below to view:

http://www.dhs.wisconsin.gov/publications/p1/p16091.pdf

GUIDE TO APPLYING

The Guide to Applying provides information on:

- Who can Enroll
- How to Apply
- What Information Needs to be Provided
- What Information Needs to be Proved and How
- Benefits and Services Available
- Rights and Program Rules
- Fair Hearing Information

Contact Information

IM AGENCY INFORMATION

Throughout Wisconsin there are 10 Consortia, 11 tribal agencies and Milwaukee Enrollment Services (MilES). Click the link below to view a map and contact information for each consortia and tribal agency.

http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

Note: These IM agencies process applications and determine eligibility for BC+ and EBD Medicaid. ADRCs are the access point for Family Care and related Long Term Care application submission.

How To Apply

HOW TO APPLY

Individuals can request benefits and complete an application using a variety of methods. The business flow for each method varies from IM agency to IM agency.

HOW TO APPLY

A customer may use the following methods to contact or initiate an application:

Online through ACCESS.wi.gov

Walk-In (Face to Face)

Phone Call

Mail-In Application

ACCESS

ACCESS

- The ACCESS website is a fast, easy-to-use benefits application and maintenance tool. Potential and existing members can use it to perform a variety of functions anywhere at anytime.
- Please note that ACCESS works best with Internet Explorer 8 or 9.
- The ACCESS website can be accessed at **www.ACCESS.wi.gov**

ACCESS


YOU ARE ON WISCONSIN.GOV
ACCESS
Your Connection to Programs for Health, Nutrition and Child Care
Español
Help
Before you go to the next page:
ACCESS will work best with Internet Explorer version 8 and 9. You may experience problems if you are using other browsers such as Firefox, Safari, or Chrome. If you have questions or need help with your application, please call Member Services at 1-800-362-3002.
Am I Eligible?
> Nutrition, Health & Child Care
> Prescription Drug Plans
> Energy Assistance
> Tax Credits
Apply for Benefits!
> FoodShare
> Health Care
> Family Planning Waiver
> Child Care
Login to Account
> Check your benefits
> Report changes
> Renew your benefits
> Manage health care
OR Create an Account

ACCESS

- The ACCESS Home Page contains four buttons that you can click to use ACCESS:
  - **Am I Eligible** – find out what benefits you might be able to get (no login needed).
  - **Apply For Benefits** – apply for Child Care, FoodShare, Health Care or Family Planning Waiver benefits (login needed).
  - **Login to Account** – check benefits, renew benefits, report changes, and perform other functions.
  - **Create an Account** – link to create a new ACCESS account.
- When using ACCESS to perform benefit maintenance, members must input their case number, social security number, and birth date to link their case information to the myACCESS account.

ACCESS

All of the customer tools and ACCESS pages are available in Spanish by clicking the “Español” link at the top of each page.

Whenever using ACCESS, you can get help by clicking on the “Help” button in the upper right of your screen. This will explain more about what we are asking and how a customer should answer questions.

ACCESS Training Environment

The ACCESS Training Environment is also available where you can test drive the site without actually creating a valid application. It is a mock environment of the “live” ACCESS website.

ACCESS Training Environment

The ACCESS Training Environment does **NOT** create a valid application.

The ACCESS Training Environment can be accessed at **https://trn.access.wisconsin.gov/**

Note: This Website should only be used for testing and training.

Walk-In (Face To Face)

WALK-IN (FACE TO FACE)

A customer has the option to apply face-to-face at their local county agency office. To view the local county agency office locations, click the link below:

http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

Telephone

TELEPHONE

Each consortium in Wisconsin has a Call Center available as one point of contact. The Call Center is the number a customer would call if they choose to apply by phone. To view the Call Center Information for each Consortium, click the link below:

http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

Mail-In Application

MAIL-IN APPLICATION

A customer can choose to submit an application via mail. The application must be signed and dated. Click the link below to view a BadgerCare Plus Application Packet.

http://www.dhs.wisconsin.gov/forms/F1/F10182.pdf

Covered Services

COVERED SERVICES

To see a current listing of covered services, click the link below. The covered services listed below this link may change. To see if a service needed is covered, members should ask their health care provider.

http://www.dhs.wisconsin.gov/forwardhealth/EandB/eandb48.htm

COVERED SERVICES

BC+ Standard Plan Covered Services may include:

- Ambulatory Surgical Centers
  - Certain surgical procedures and related lab services
- Chiropractic Services
- Dental Services
- Disposable Medical Supplies
- Prescription Medications
- End Stage Renal Disease
- Health Screenings for Children
- Hearing Services
- Home Care Services
  - Home Health, Private Duty Nursing and Personal Care

COVERED SERVICES

BC+ Standard Plan Covered Services may include (continued):

- Hospice
- Inpatient Hospital Services
- Mental Health and Substance Abuse Treatment
- Nursing Home Services
- Outpatient Hospital
  - Emergency Room
- Physician Services
- Podiatry Services
- Prenatal/Maternity Care

COVERED SERVICES

BC+ Standard Plan Covered Services may include (continued):

- Therapy
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech and Language Pathology (SLP)
- Transportation
  - Ambulance
  - Specialized Medical Vehicle (SMV)
  - Common Carrier
- Vision
  - Routine Services

COVERED SERVICES

Family Planning Only Covered Services may include:

- Reproductive Health Services — Family Planning Services
  - Excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization.

SERVICES COVERED

Some examples of EBD Medicaid covered services include:

- Chiropractic services
- Dental services
- Family planning services and supplies
- Home and community-based services authorized under a waiver
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease
- Laboratory and X-ray services

SERVICES COVERED

Some examples of EBD Medicaid covered services include (continued):

- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services
- Nursing services, including services performed by a nurse practitioner
- Optometric or optical services, including eyeglasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services

SERVICES COVERED

Some examples of EBD Medicaid covered services include (continued):

- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Respiratory care services for ventilator-dependent individuals
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other abuse services)
- TB (tuberculosis) services
- Transportation to obtain medical care

If members have additional questions about covered services or EBD Medicaid and BadgerCare Plus, they should contact Member Services at 1-800-362-3002.

COVERED SERVICES

Services NOT Covered Under Any Plan

Services or items not covered include (but are not limited to):

- Items such as televisions, radios, lift chairs, air conditioners, and exercise equipment (even if prescribed by a physician),
- Procedures considered experimental or cosmetic in nature, and
- Services that need approval (prior authorization) before a member gets them.

Copays and Premiums

COPAYS AND PREMIUMS

Copays:

Some services require members to pay a part of the cost of that service. This is called a copayment or copay. Co-pays range from $0.50 to $3.00. Providers are required to make a reasonable effort to collect the co-pays, but may not refuse services to a member who fails to make that payment. For more information about copays, go to the website below:

http://www.dhs.wisconsin.gov/forwardhealth/EandB/eandb48.htm

COPAYS AND PREMIUMS

Premiums:

Some members may have to pay a monthly premium to enroll in BadgerCare Plus. The first monthly premium payment(s) must be paid to the local Income Maintenance agency before members can enroll. For more information on premiums, go to the website below:

http://www.dhs.wisconsin.gov/forwardhealth/EandB/eandb46c.htm

What to Expect after an Application is Filed

VERIFICATION REQUIREMENTS

Verification Requirements

Verification is part of determining eligibility for public assistance health care programs in Wisconsin. To verify means to establish the accuracy of verbal or written statements made about an individual's circumstances. Submitting proof is a method by which applicants and members accomplish verification.

The items required for verification will depend on the applicant's situation. The different mandatory verification items and sources of verification can be found in the respective program's handbook (BadgerCare Plus Handbook or Medicaid Eligibility Handbook), found by clicking on "*Handbooks and Manuals*" at the website below:

http://www.dhs.wisconsin.gov/em/index.htm

COMMON VERIFICATION ITEMS

Some commonly required verifications items are:

- Identity
- Earnings from a job
- Citizenship
- Assets, if applicable
- Out of State Unemployment Benefits

DATA EXCHANGE

The Wisconsin State Data Exchange can be used to verify information. If the worker is able to verify information through the Data Exchange, the customer does not have to provide proof. See below for information verified through Data Exchange:

- Wisconsin Unemployment Benefits
- Social Security
- Supplement Security Income

VERIFICATION CHECKLIST

If information is not able to be verified through the state's data exchange, the agency will issue the applicant a Verification Checklist (VCL).

VERIFICATION CHECKLIST

A verification checklist is sent to the applicant/member when a assistance program application is pending verification or other information.

VERIFICATION CHECKLIST

The verification notice:

- Includes verification requirements for BC+ and/or EBD Medicaid, as applicable.
- Provides the correct due dates according to program policy.
- Is divided into different sections based on what is pending on a particular case.
- Contains relevant, specific examples of documents that are needed.
- Includes a Document Tracking Sheet, which provides details on how the customer/member can submit their verifications.

VERIFICATION CHECKLIST EXAMPLE

The next two slides will show a sample of a Verification Checklist.

Notice of Proof Needed

To get or keep **BadgerCare Plus** benefits you need to provide proof of items and provide information by the due date listed below. The items that need proof we need you to provide are listed on the next few pages along with examples and instructions. If you do not provide the proof by the due date, benefits will be denied, decreased, or ended.

To make sure your benefits get processed as quickly as possible, use the **Document Tracking Sheet** at the end of this notice.

Program(s)	Due Date	Contact Information
BadgerCare Plus	Apr. 15, 2014	**Southern Consortium** Worker: [redacted] Phone #: [redacted] Fax #: [redacted] Use fax # to send verification.

VERIFICATION CHECKLIST

Proof Needed

This section lists items that we need proof of by the due date listed below. Contact us right away if you have questions or problems getting the proof and we will help you.

What?	Who?	Examples	Program(s)	Due Date
Employment at **WALMART** including : Expected monthly income before taxes or deductions and number of hours worked per pay period	[redacted]	Pay Stubs from the last 30 days; enclosed Employer Verification of Earnings Form filled out and signed by your employer; or Statement from your employer with the same information.	BadgerCare Plus	Apr. 15, 2014
Self-employment: **MICHAEL - BAKERY** Including : Expected monthly business income	[redacted]	Enclosed Self-Employment Income Report Form	BadgerCare Plus	Apr. 15, 2014

Possible Outcomes

NOTICES AND CHECKLISTS

After an applicant submits an application he/she will receive a letter (Notice of Decision (NOD) and/or Verification Checklist (VCL)) from the local agency to inform him/her of the status of their request and/or benefits. It's important that customers read the letter they receive in a timely manner as it will contain important information with possible deadlines.

NOTICES AND CHECKLISTS

These letters will inform customers if:

- Their benefits are being approved or denied, or
- The local agency needs additional information (or proof) from them in order to finish processing their request.

POSITIVE NOTICE OF DECISION

If benefits are approved, the customer will receive a positive NOD. The following information will be on this notice:

- **Summary:** This page gives a short review of the case as well as what benefits are approved and the contact information for the local agency.
- **Benefit Details:** This page will give details about benefits such as:
  - Who is enrolled
  - Dates enrolled
  - Who is not enrolled
  - If not enrolled, the reason(s) why

POSSIBLE OUTCOMES

If benefits are approved, the customer will receive a positive NOD. The following information will be on this notice (continued):

- **Household Income:** This section has a list of the income on file for the household. Members should check their letters to make sure all income information is correct.
- **Household Deductions:** This section has a list of deductions on file for the household.
- **How We Counted the Income:** This section has the amounts and limits that were used to decide whether the member is eligible.

POSITIVE NOTICE OF DECISION

If benefits are approved, the customer will receive a positive NOD. The following information will be on this notice (continued):

- **Reporting Rules:** This page has the reporting rules, which tell members what changes need to be reported to the local agency, and the timeframe.
- **Key Contacts:** This page has key contacts. The key contacts give information about who members should contact with questions.
- **Fair Hearing:** The last page of the letter has information about fair hearings. The date by which a hearing must be requested and how to ask for a fair hearing.

FAIR HEARING

- If benefits are denied, reduced or ended, and the customer believes the agency made a mistake, they should contact the agency
- If the applicant does not agree, the applicant can ask the agency worker to help in requesting a Fair Hearing.
- A Fair Hearing gives the applicant a chance to tell a hearing officer why they think the decision about their application or benefits was wrong.
  - At the hearing, a hearing officer will hear from the customer and the agency to find out if the decision was right or wrong, and inform the agency to take action as appropriate.

FORWARDHEALTH CARD

ForwardHealth Cards:

- Each person enrolled in BC+ will receive a ForwardHealth Card which should be shared with providers when services are requested.
- The ForwardHealth card does not show the dates that members are enrolled, but does have the customers name and ID number.
- Members will get an Enrollment Letter in the mail from the agency with the dates of enrollment.

The Right to Apply and Rights and Responsibilities

RIGHT TO APPLY

- All applicants have the right to file an application on the day of their first contact with a local IM agency.
- Local IM agencies may not refuse anyone the right or the opportunity to apply if s/he chooses to do so.
- S/he must be allowed to apply and set the filing date whether or not the person is in the correct office or region.

RIGHTS AND RESPONSIBILITIES

- Wisconsin Statute 49.81 is called the "Public Assistance Recipients' Bill of Rights."
  - This statute mandates that "…all public and relief granting agencies shall respect the rights for recipients of public assistance."
- These rights apply to anyone applying for or receiving BadgerCare Plus or Medicaid.

MEMBER RIGHTS

Everyone applying for or getting BadgerCare Plus and/or Medicaid has the right to:

- Be treated with respect by agency staff.
- Have their civil rights upheld.
- Have their private information kept private.
- Get an application or have the application mailed on the same day it is asked for.
- Have an application accepted right away by the agency.
- Get a decision about their application within 30 days of the day the agency gets the application.

MEMBER RESPONSIBILITIES

Everyone applying and/or receiving BadgerCare Plus and/or Medicaid has the responsibility to provide accurate answers as well as proof of their answers for BadgerCare Plus and Medicaid, when applying for benefits, renewing benefits or reporting changes.

For more information on customer rights and responsibilities, go to the Enrollment and Benefits Brochure, website below:

http://www.dhs.wisconsin.gov/publications/p0/p00079.pdf

ADDITIONAL RESOURCES

Additional Online Resources, including Policy Manuals, Operations Memos, fact sheets, directories, etc. can be found at the website below:

http://dhfs.wisconsin.gov/em/index.htm

Do & Don't Reminder

DO & DON'T LIST

As a Navigator or CAC, there are a few things to keep in mind as you assist customers:

Do:	Don't:
• Establish a relationship with local consortia • Learn how to navigate the ACCESS application • Learn how to access the Marketplace • Establish a relationship with ADRCs	• Attempt to answer questions about eligibility • Print out materials related to consortia contacts, Enrollment and Benefits or FPL income criteria; instead rely on accessing the information online to ensure that you have the most up-to-date information

Questions?

Please direct all questions related to Medicaid/BadgerCare Plus and this training to:

dhshealthcare@dhs.wisconsin.gov

Self Check

SELF CHECK

Who are the BC+ potential members?

A. Children under 19 years of age
B. Pregnant Women
C. Parents and caretakers
D. Young adults leaving foster care
E. Childless Adults
F. All of the above

F. All of the above

SELF CHECK

What is one income type NOT counted for BC+?

A. Earned Income
B. Child Support
C. Unemployment Compensation
D. Pension

B. Child Support

SELF CHECK

There is no asset limit for BC+.

True
False

True

SELF CHECK

An individual under 19 years old is considered a child for BC+.

True
False

True

SELF CHECK

A customer can submit a valid application at https://trn.access.wisconsin.gov/.

True
False

False *(A customer can submit a valid application at www.ACCESS.wi.gov.)*

SELF CHECK

On the ACCESS website, all of the customer tools and ACCESS pages are available in Spanish.

True
False

True

SELF CHECK

What are some conditions of eligibility that an individual must meet?

A. Be a Wisconsin Resident
B. Cooperate with verification requests on mandatory or questionable information
C. Prospective income must be below program limits
D. Be a US Citizen or qualifying immigrant
E. All of the above

E. All of the above

SELF CHECK

Fill in the blank:

"A ***Verification*** ***Checklist*** is sent to the applicant/member when a program of assistance is pending verification or other information."

SELF CHECK

The income limit for a Pregnant Women is at or below 300% of the FPL.

True
False

True

SELF CHECK

The income limit for a Parent or Caretaker is at or below 300% of the FPL.

True
False

False *(The income limit for a Parent or Caretaker is at or below 100% of the FPL.)*

SELF CHECK

Fill in the blank:

"Each person enrolled in BC+ will receive a ***Forward Health*** Card."

SELF CHECK

What are the methods of applying for Health Care assistance in Wisconsin?

A. ACCESS
B. Mail-In Application
C. Face to Face (Walk-In)
D. Telephone
E. All of the above

E. All of the above

Thank you for completing Applying for Public Health Care Assistance in Wisconsin: Overview for Navigators and Certified Application Counselors!